MERCYHEALTH
Cincinnati SportsMedicine
& Orthopaedic Center

Five Offices, One Number: 513-347-9999 *Fax*: 513-792-3230 *On the web*: www.cincinnatisportsmed.com

MONTGOMERY	MASON	TRI-COUNTY	WESTERN HILLS	NORTHERN KENTUCKY
10663 Montgomery Rd. CIncinnati, OH	7423 Mason-Montgomery Rd. Mason, OH	12115 Sheraton Lane Cincinnati, OH	6350 Glenway Ave Cincinnati, OH	328 Thomas More Pkwy. Crestview Hills, KY

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Orthopaedic History

PATIENT NAME: ***Last*** ________ ***First*** ________ ***MI*** ____ ***Appointment Date*** ________

Date of Birth ________ ***Age*** ________ ***Sex*** ☐ Male ☐ Female ***Please print clearly***

WHAT IS YOUR CHIEF COMPLAINT AT THIS TIME: ☐ Right ☐ Left ________

____

HOW LONG HAS THE PROBLEM BEEN PRESENT/WHEN DID IT BEGIN ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ No Specific Event

☐ **Specific Event - please explain:** ________

WHEN DOES THE PROBLEM OCCUR *(i.e. a certain time of day, with specific activities)* ________

____

IS THIS PROBLEM THE RESULT OF AN INJURY ☐ YES ☐ NO **DATE OF INJURY** ________ **DID IT OCCUR AT WORK?** ☐ YES ☐ NO

IS YOUR INJURY DUE TO A MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO **WERE YOU THE** ☐ DRIVER ☐ PASSENGER

WERE YOU WEARING YOUR SEATBELT ☐ YES ☐ NO **DID THE AIRBAG DEPLOY** ☐ YES ☐ NO **ATTORNEY RETAINED** ☐ YES ☐ NO

DID YOU GO TO THE ER ☐ YES ☐ NO **IF YES, WHICH HOSPITAL** ________ **DATE** ________

WHAT WAS THE NAME OF THE PHYSICIAN THAT TREATED YOU IN THE ER ________

HOW WAS YOUR INJURY TREATED IN THE ER ________

RESULTS OF TREATMENT UP UNTIL NOW ________

THINGS THAT MAKE YOUR SYMPTOMS BETTER ________

THINGS THAT MAKE YOUR SYMPTOMS WORSE ________

LIST ANY OTHER PREVIOUS ORTHOPAEDIC INJURIES, CONDITIONS, OR BROKEN BONES RELATED TO YOUR PRESENT CONDITION:

DATE	TYPE OF INJURY/CONDITION	TREATMENT *(injections, meds, surgeries, PT)*	WORK RELATED
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

Past Medical History

COULD YOU BE PREGNANT ☐ YES ☐ NO ***IF YES, MAKE SURE NO X-RAYS ARE TAKEN, PLEASE NOTIFY X-RAY TECHNICIAN!!***

HEIGHT: ______ **WEIGHT:** ______

DO YOU HAVE A PERSONAL HISTORY OF CANCER? ☐ YES ☐ NO

PLEASE LIST ALL PRIOR SURGERIES OR SERIOUS ILLNESSES IN THE BOXES PROVIDED BELOW:

DATE(S):	***TYPE OF SURGERY OR SERIOUS ILLNESS:***	***DATE(S):***	***TYPE OF SURGERY OR SERIOUS ILLNESS:***

HAVE YOU EVER HAD GENERAL ANESTHESIA? ☐ YES ☐ NO **DID YOU HAVE ANY PROBLEMS WITH ANESTHESIA?** ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE ANY COMPLICATIONS YOU HAD WITH ANESTHESIA IN THE SPACE PROVIDED BELOW.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING ANY OVER-THE-COUNTER MEDICATIONS AND/OR HERBAL OR NUTRITIONAL SUPPLEMENTS) IN THE SPACES PROVIDED BELOW

Medication/Dosage	***Reason for taking medication***	***Medication/Dosage***	***Reason for taking medication***

DO YOU HAVE ANY ALLERGIES? (Certain medications, betadine, iodine, latex, etc.) ☐ YES ☐ NO

IF YES, PLEASE LIST ______

DO YOU TAKE BLOODTHINNERS? (Coumadin, aspirin, etc.) ☐ YES ☐ NO

iF YES, PLEASE LIST ______

Social History

EDUCATION: ☐ GRADE SCHOOL ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

EMPLOYMENT: ☐ STUDENT ☐ UNEMPLOYED ☐ RETIRED ☐ WORK FROM HOME

☐ EMPLOYED *Please list occupation:* ______

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

DO YOU LIVE ALONE? ☐ YES ☐ NO DO YOU HAVE CHILDREN? ☐ YES ☐ NO NUMBER OF CHILDREN: ______

Social History *cont.*

EXERCISE: ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ RARELY ☐ NEVER

TYPE OF EXERCISE:

SPORTS PARTICIPATION ☐ HIGH SCHOOL ☐ COLLEGE ☐ CLUB ☐ RECREATIONAL ☐ PROFESSIONAL

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? (Chemical dependency, recreational drug use, etc.) ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

DO YOU SMOKE CURRENTLY? ☐ YES ☐ NO **IF YES, HOW MANY PACKS/DAY** **FOR HOW MANY YEARS?**

QUIT SMOKING: ☐ THIS YEAR ☐ MORE THAN 1 YR AGO ☐ MORE THAN 5 YRS. AGO ☐ MORE THAN 10 YRS AGO

PRIOR TO QUITTING, HOW MANY PACKS WERE YOU SMOKING PER DAY? **FOR HOW MANY YEARS?**

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO *IF YES, PLEASE DISCLOSE BELOW THE FREQUENCY IN WHICH YOU DRINK, AS WELL AS THE APPROXIMATE NUMBER OF DRINKS YOU HAVE PER DAY, WEEK, MONTH, YEAR.*

☐ DAILY # ☐ WEEKLY # ☐ MONTHLY # ☐ YEARLY #

Family Health History

List all medical issues in the spaces provided below

FATHER ☐ ALIVE ☐ DECEASED AGE

MOTHER ☐ ALIVE ☐ DECEASED AGE

SISTER/BROTHER ☐ ALIVE ☐ DECEASED AGE

SISTER/BROTHER ☐ ALIVE ☐ DECEASED AGE

SISTER/BROTHER ☐ ALIVE ☐ DECEASED AGE

SISTER/BROTHER ☐ ALIVE ☐ DECEASED AGE

Work History -- Complete this section only if your injury is affecting your job performance

EMPLOYER:

DOES YOUR JOB OFFER YOU LIGHT OR LIMITED DUTY AS AN OPTION TO RETURN TO WORK? ☐ YES ☐ NO ☐ NOT SURE

HAVE YOU HAD TO MISS WORK DUE TO YOUR INJURY OR INABILITY TO PERFORM AT WORK? ☐ YES ☐ NO **HOW MUCH?**

PLEASE DESCRIBE YOUR JOB DUTIES IN THE SPACE PROVIDED BELOW

WHAT DUTIES BRING YOU PAIN?

IF ANY OF YOUR JOB DUTIES HAVE CHANGED TO ACCOMODATE YOUR CONDITION, PLEASE DESCRIBE BELOW

PLEASE LIST ANY OTHER PREVIOUS WORK RELATED INJURIES, NOT DESCRIBED ABOVE, IN THE SPACE PROVIDED BELOW

Date	*Injury*	*Physician*	*Treatment*

Review Of Systems

Please check any current positive findings by marking the boxes. If all findings are negative, please mark the circle directly to the right of each system.

System					
Constitutional	○	☐ Weight Loss	☐ Fevers	☐ Chills	☐ Poor Appetite
		☐ Fatigue	☐ Weight Gain	☐ Insomnia	☐ Night Sweats
Eyes	○	☐ Blurry Vision	☐ Eye Pain	☐ Eye Discharge	☐ Eye Redness
		☐ Decrease in vision	☐ Dry eyes	☐ Double Vision	☐
ENT	○	☐ Sore throat	☐ Hoarseness	☐ Ear pain	☐ Hearing Loss
		☐ Ear discharge	☐ Nose bleeds	☐ Tinnitus	☐ Sinus problems
Cardiovascular	○	☐ Chest Pain	☐ Palpitations	☐ Rapid heart rate	☐ Heart murmur
		☐ Poor circulation	☐ Swelling in legs/feet	☐	☐
Respiratory	○	☐ Shortness of Breath	☐ Chronic cough	☐ Coughing up blood	☐ History of Tuberculosis
		☐ Excess sputum production	☐	☐	☐
Gastrointestinal	○	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
		☐ Blood in the stool	☐ Frequent heartburn	☐ Trouble swallowing	☐
Genitourinary	○	☐ Increased urinary frequency	☐ Blood in the urine	☐ Incontinence	☐ Painful urination
		☐ Urinary retention	☐ Frequent UTIs	☐	☐
Skin	○	☐ Rash	☐ Hives	☐ Hair loss	☐ Skin sores or ulcers
		☐ Itching	☐ Skin thickening	☐ Nail changes	☐ Mole changes
Musculoskeletal	○	☐ Joint pain	☐ Muscle aches	☐ Frequent leg cramps	☐ Muscle weakness
		☐ Bone pain	☐ Joint swelling	☐ Back pain	☐
Psychiatric	○	☐ Anxiety	☐ Depression	☐ Alcohol or drug dependence	☐ Suicidal thoughts
		☐ Panic attacks	☐ Use of anti-depressant	☐	☐
Endocrine	○	☐ Goiter	☐ Heat intolerance	☐ Cold intolerance	☐ Increased thirst
		☐ Change in skin pigment	☐ Excess sweating	☐	☐
Neurological	○	☐ Seizures	☐ Tremors	☐ Migraines	☐ Numbness
		☐ Dizziness/Vertigo	☐ Loss of balance	☐ Slurred speech	☐ Stroke
Hem/Lymphatic	○	☐ Low blood count	☐ Easy bruising	☐ Swollen lymph nodes	☐ Transfusions
		☐ Prolonged bleeding	☐ Blood clots	☐	☐
Allergic/Immun	○	☐ Allergic reactions	☐ Hay fever	☐ Frequent infections	☐ Hepatitis
		☐ HIV positive	☐ Positive TB skin test	☐	☐

PLEASE EXPLAIN ANY POSITIVE FINDINGS TO THE REVIEW OF SYSTEMS IN THE SPACE PROVIDED:

PATIENT SIGNATURE: ______________________ DATE: __________

PHYSICIAN REVIEWING: ______________________ DATE: __________